

## Author's further response

*Dr Jason Payne-James*

Thank you for forwarding to me the response letter from Dr Pressman. Thank you also for requesting this final response from myself. I have reviewed this letter and my response is as follows:

It is clear from Mr Pressman's introductory remarks that he is not in possession of the facts of this case and confuses the content of the case report with that of the court case. Mr Pressman asserts that we have presented the HSDWA as diagnostic in court – this assertion is false. In this court case, three sleep experts' opinions were sought, myself for the defence, another independent UK based sleep expert for the prosecution and thirdly, an eminent North American sleep expert in Sexsomnia was consulted during the proceedings. All three experts were provided full access to all information and tests including PSG data.

There was agreement on the diagnosis and the findings on PSG.

There is no mention of HSDWA in any of the reports and in fact my report states clearly:

*“..these findings are in no way diagnostic of sleepwalking and cannot be extrapolated to the behaviour on the night in question”.*

This statement is confirmed by the prosecution expert's report when he states that:

*“Again, as Dr Ebrahim has emphasised this in itself does not establish that on this particular night JB was acting in an automatic state and this will be a matter for the jury to decide”.*

My report also states

*“It must be emphasised that as in the diagnosis of any medical condition the diagnosis does not rest purely on the results of investigations, but rather on the analysis of all data including the history, physical examination, mental state, cognitive state and the results of tests and investigations. Very important are the facts of the case and the behaviour during the ‘event’ all of which must fit that of a sleep walking episode.”*

The issue of the EEG changes that may or may not indicate sleepwalking were included in the case report i.e. this article as a matter of interest for academic discussion and debate.

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Mr Pressman's assertion that HSDWA is used in court as diagnostic of sleepwalking is therefore a false assertion not borne out by the facts of the case.

**Statement 1** (page 221, right column, 2nd line from bottom):

This statement is not controversial and states clearly that in the forensic arena objective criteria are important – in this case objective criteria were essential – had the defendant not had sleep studies, his diagnosis of sleep disordered breathing would not have been made and his defence would have been compromised. This is further reinforced by recommendations made in a previous publication by two of Mr Pressman's co-authors – Dr C H Schenck and Dr M W Mahowald –

*“Clinical evaluation should include a complete review of sleep/wake complaints from both the victim and bed partner (if available). This should be followed by a thorough general physical, neurological and psychiatric examination. The diagnosis may only be suspected clinically. Extensive polygraphic study employing an extensive scalp EEG at a paper speed of 15 mm/sec, electromyographic monitoring of all four extremities and continuous audiovisual recording are mandatory for correct diagnosis in atypical cases”.*

Mahowald M, Schenck C. Parasomnias: sleepwalking and the law. Sleep Medicine Reviews 2000, Vol. 4, No. 4, pp. 321–339.

**Statement 2** (page 222, left column, 22 lines up from bottom):

This statement in the article is followed by a discussion of the features reported in previous reports and the controversial nature of these findings is highlighted with the reader provided the relevant references.

**Statement 3** (page 223, left column, 17 lines from bottom):

As I mentioned in my previous letter, this paragraph is clearly incorrectly placed as it discusses EEG features under the heading of Sleep Disordered Breathing. I have previously recommended a rewording.

**Statement 4** (page 223, right column, 6 lines from top):

This is a statement of fact – none of the previous case reports of Sexsomnia have employed a three night protocol.

Mr Pressman has made several statements regarding the predictive value of finding sleepwalking or related complex behaviours on the PSG. It is interesting to note that two of his co-authors, Dr C H Schenck and Dr M

Mahowald have previously published a case report in which they argue for a reclassification of forensic sleep-walking risk based on a single case study. In addition, in the same case report the authors argue for repeated PSG monitoring of Forensic Cases as outlined in their concluding remarks below:

*“One can thus predict that there will be forensic parasomnia cases in which the most prudent clinical and legal/public safety course to follow would be to PSG-monitor the sleep of the accused each night...until the diagnosis is established, and other possible diagnoses are excluded.”*

Schenck CH & Mahowald MW. A polysomnographically documented case of adult somnambulism with long-distance automobile driving and frequent nocturnal violence: Parasomnia with continuing danger as a Non-Insane Automatism. *SLEEP* 18(9):765–772.

Mr. Pressman notes that unvalidated tests should never be used for forensic or clinical purposes. This sentence turns on the use of ‘unvalidated’. The use of the polysomnogram for the diagnosis of sleep disorders is routine and widely accepted. It is scientifically accepted that sleepwalking episodes may occur while the polysomnogram is being taken, and if so, they indicate that on that night the patient did sleepwalk. None of this is conjecture.

In addition, Mr Pressman states that we utilise a 3 night battery of tests to recreate the conditions at the scene of the crime – this is an incorrect statement. We are in no way attempting to recreate the conditions of the scene of the crime as this would be impossible.

Sleepwalking/automatism cases usually come to the attention of sleep experts because the defendant has no memory of the events of the night. It is thus important, as a clinician, to look at all the factors which might have led to this loss of memory. These may have organic or behavioural causes. Behaviourally, the defendant may simply be lying, and have a perfect memory. This must be put forward as a possibility. Secondly, there may be psychological suppression of memory and the factors looking at the exact nature of the memory loss will allow the clinician to say on the balance of probability this is likely to have been the cause. Next, organic factors should be looked at. If alcohol had been taken then the use of scientific data to establish the probable blood alcohol level (if it was not measured) will be used and from our knowledge of blood alcohol and memory function it will be possible to infer whether an alcoholic blackout might have occurred. If sleep was involved, then it is reasonable to carry out a polysomnogram and see whether if alcohol is given to **that individual** there is a significant alcoholic blackout or other abnormality. If the patient’s memory is affected to the extent that it was at the time of the offence then it is reasonable to argue that alcohol may have played a part in the memory loss described by the defendant. Other organic factors such as epilepsy, dementia, etc. will also be considered and the relevant tests car-

ried out, all with the aim of determining the integrity of the defendant’s memory at the time of the tests and then inferring from the patient’s history whether these factors could have been present at the time of the offence. None of this contradicts science.

The defendant may not only have a memory loss for the offence; there may also be evidence that he carried out a number of acts at the time of the memory loss and the question before the court is then whether these were due to some organic process. Clearly some of the factors described above will be important in these circumstances. Epilepsy, for example, is a clinical diagnosis and the description of seizures by the defendant should be sufficient to make the diagnosis, but support for the diagnosis will be sought in EEG tests and confirmation of the diagnosis will be sought for the recording of a seizure at the time that the EEG is taken, thus indicating a disorder of consciousness and abnormal brain electrical activity. From the patient’s history it is then possible to infer whether seizures could, on the balance of probability, have occurred at the time of the offence. This can only be inference and not proof as usually no one is present to witness the offence and report the defendant’s exact behaviour (this was not true in the case of *R v Sullivan*, the key English case, where the defendant’s seizure was witnessed). Other organic causes for abnormal behaviour such as a dementing illness, a confusional state following a head injury, or due to alcohol or drug intoxication, will all be dealt with the same way. Clinical description of behaviour first, likely clinical diagnosis made on clinical grounds, with supportive evidence from tests.

There is a significant literature on the association of Alcohol with Sleepwalking. It is our opinion that by not assessing that particular individual’s response to alcohol would be a dereliction of duty as it would leave important questions unanswered. Similarly, in a case where an Insulin induced hypoglycaemia may be responsible for an automatism, it would be essential to assess that particular individual’s response to Insulin.

The references listed below are some of the pertinent papers on the relationship between Alcohol, Sleepwalking and Forensic implications:

- Buchanan A. Sleepwalking and indecent exposure. *Med Sci Law* 1991;31:38–40.
- Fenwick P. Automatism. In Bluglass (ed). *Principles and Practice of Forensic Psychiatry* 271–285.
- Hartman EH Two case reports: Night terrors with sleep-walking – A potentially lethal disorder. *J Nervous and Mental Dis* 1983;171(8):503–505.
- Lobo LL, Tufik S. Effects of alcohol on sleep parameters of sleep deprived healthy volunteers. *Sleep* 1997;20:52–59.
- Marlowe DB, Lambert JB, Thompson RG. Voluntary intoxication and criminal responsibility. *Behav Sci Law* 1999;17:195–217.

- Podolsky E. Somnambulistic homicide. *Am J Psychiatry* 1964;21:91–2.
- Raschka LB. Sleep and violence. *Can J Psychiatry* 1984;29(2):132–134.
- Schenck CH, Mahowald MW. An analysis of a recent criminal trial involving sexual misconduct with a child, alcohol abuse and a successful sleepwalking defense: arguments supporting two proposed new forensic categories. *Med Sci Law* 1998;38(2): 147–52.
- Thomas TN. Sleepwalking and mens rea: a review and case report. *J Forensic Sci* 1997;42(1):17–24.
- van Oorsouw, Merckelbach H, Ravelli D, Nijman H, Mekking-Pompen I. Alcoholic blackout for criminally relevant behavior. *J Am Acad Psychiatry Law* 2004;32:364–70.
- Yules RB, Lippman ME. Alcohol administration prior to sleep: the effect of EEG sleep stages. *Arch Gen Psychiatry* 1967;16:94–97.

I would like to thank the editor for inviting my comments and hope that the issues raised have now been adequately addressed.

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